FYZICAL
Therapy & Balance Centers

Patient Information:

Last Name: _____ First Name:_____ Middle Initial:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____Sex:_____

Home Phone #:_____ Cell #:_____ Work #:_____

Email Address: _____ Marital Status: Single____ Married ____ Divorced____

Emergency Contact: Name: _____Phone Number: _____

Primary Care Physician: _____ Location: _____

Are you currently under the care of a Home Health Agency? Yes:__ No:__ Name of Co:_____

How did you hear about FYZICAL? _____

Insurance Information

Primary Insurance ID#:_____ Phone #:_____

Secondary Insurance ID#:_____ Phone #:_____

Policy Holder's Name:_____ Relation to Patient: _____ DOB:_____

Consent for Treatment:

I hereby consent to receive care for physical therapy services by Greylock Audiology LLC/FYZICAL. I consent to medical treatment as deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information:

I authorize Greylock Audiology LLC/FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

Consent to Obtain Medical Information:

I authorize Greylock Audiology LLC/FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-ray, CT and/or MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefit:

I hereby authorize payment to be made directly to Greylock Audiology LLC/FYZICAL.

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible party signature: _____ Date: _____